InfuCare Rx®

Vyvgart® & Vyvgart® Hytrulo Enrollment Form

Fax Referral To: 877-828-3941
Phone: 877-828-3940

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

DIAGNOSIS

☐ G70.00 Myasthenia Gravis without (acute) exacerbation
☐ G70.01 Myasthenia Gravis with (acute) exacerbation
☐ G61.81 Chronic Inflammatory Demyelinating Polyneuropathy (CIPD)

☐ Patient's demographics, including insurance information
☐ Clinical/Progress notes with supporting diagnosis
☐ H&P

MG Indication:

☐ Positive serologic test for anti-AChR antibody for gMG
☐ MG-ADL Score: _____ ☐ MGFA classification: _____

CIDP Indication:

☐ Biopsy Results ☐ Electromyography (EMG) Results ☐ CSF Studies
☐ INCAT ☐ RODS ☐ mRS

☐ Original Prescription Orders Attached

Previous therapies: ☐ eculizumab ☐ rituximab ☐ IVIG
☐ oral corticosteroids ☐ non-steroidal ISTs

MEDICAL HISTORY

Patient Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____
Line Access: ☐ Peripheral ☐ PICC ☐ Port
Therapy Start Date: _____ Therapy End Date: _____

☐ Current medications: _____
☐ Previous live vaccine: _____ Date: _____

Nursing Coordination:

☐ Pharmacy to coordinate home health nursing visit as necessary: ☐ Yes ☐ No
☐ Home health nursing coordination not necessary. Reason:
  ☐ MD office to administer to patient
  ☐ Home health nursing already coordinated

PRESCRIPTION INFORMATION

Vyvgart® (efgartigimod alfa-fcab) Prescription:	**Dispense:**
☐ 10mg/kg body weight weekly for 4 doses. (Once weekly x 4 weeks.) Maximum dose: 1.2gm. Subsequent treatment cycles may be administered based on clinical evaluation and no sooner than 50 days from the start of the previous treatment cycle.	4 doses
☐ Subsequent treatment cycles to be determined	no refills
☐ Subsequent treatment cycles to be every 50 days from the start of the previous treatment cycle	7 refills
☐ Subsequent treatment cycles to be every _____ days from the start of the treatment cycle	____ refills
Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) Prescription for generalized Myasthenia Gravis:	
☐ 1,008 mg/11,200 units (5.6mL) subcutaneous injection over 30-90 seconds once weekly for 4 weeks. Subsequent treatment cycles based on clinical evaluation; no sooner than 50 days from the start of the previous treatment cycle. To be administered by a healthcare professional with 30 minutes post observation period.	4 doses
☐ Subsequent treatment cycles to be determined	no refills
☐ Subsequent treatment cycles to be every 50 days from the start of the previous treatment cycle	7 refills
☐ Subsequent treatment cycles to be every _____ days from the start of the treatment cycle	____ refills
Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) Prescription for Chronic Inflammatory Demyelinating Polyneuropathy (CIPD):	
☐ 1,008 mg/11,200 units (5.6mL) subcutaneous injection over 30-90 seconds once weekly. To be administered by a healthcare professional with 30 minutes post observation period.	4 doses 12 refills

ORDERS/OTHER MEDICATIONS

► **Orders are initiated:**
► Infusion supplies as per protocol
► Anaphylaxis Kit orders as per protocol

Flush Protocol (For Vyvgart® intravenous infusion only)
► NaCl 0.9% 10mL
► Before and after infusion ☐ Other: _____

Prescriber Signature: _____ **Date:** _____

Revised 14 Aug 2024